

# **INITIAL PROFESSIONAL EMPLOYER ORGANIZATION APPLICATION FOR LICENSURE MONTANA**



**The application fee is:**

       **\$750.00 Unrestricted license**

       **\$500.00 Restricted license**

**Fees Payable To:** Department of Labor and Industry  
Employment Relations Division

**Mailing Address:** PO Box 8011, Helena MT 59604-8011

**Street Address:** 1805 Prospect Avenue, Helena MT 59601

**Contact Person:** Brett Wall, PEO Compliance Specialist

**Phone :** (406) 444-0776

**Email :** [brwall@mt.gov](mailto:brwall@mt.gov)

**Web Address :** <http://erd.dli.mt.gov/wcregs/profemporgs.asp>

**Important Information  
(Must be completed)**

Corporate or Assumed Names to include DBA in Montana and FEIN(s):

\_\_\_\_\_

Street and Mailing address: \_\_\_\_\_

Branch Offices \_\_\_\_\_ Yes \_\_\_\_\_ No (If yes, attach listing of all branch locations, street addresses and phone numbers)

Contact Person(s): \_\_\_\_\_

Business phone # \_\_\_\_\_ Email(s): \_\_\_\_\_

State Unemployment Tax Account(s) (SUTA): \_\_\_\_\_

Workers' Compensation Policy Number(s): \_\_\_\_\_

Effective Date(s): \_\_\_\_\_

Name of Insurer: \_\_\_\_\_

Insurer address: \_\_\_\_\_

Insurer phone #: \_\_\_\_\_

In-State Adjuster: \_\_\_\_\_

**BENEFITS PROGRAMS:** A professional employer organization or group shall disclose to the department, to each client, and to its employees information on any health or life fringe benefit program provided for its employees.

Are benefits provided \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please complete the following information or submit as an attachment:

Type of benefits: \_\_\_\_\_

Identity of each Insurer providing coverage: \_\_\_\_\_

Amount of benefits for each type of coverage: \_\_\_\_\_

Policy limits on each insurance policy: \_\_\_\_\_

Whether coverage is fully insured, partially insured or fully self-funded: \_\_\_\_\_

# PROFESSIONAL EMPLOYER ORGANIZATION OR GROUP

## LICENSE APPLICATION in MONTANA

The Department desires to provide courteous and timely service to all applicants. In order to maximize efficiency, the Department will process **complete applications only**. Please read the instructions carefully to ensure proper completion of the application. In order to become licensed, you must submit a completed application, which includes all necessary supporting documents and a **non-refundable** application fee. The application fee is \$750 for a resident or nonresident unrestricted license, or \$500 for a restricted license.

**Application:** Failure to supply necessary information may result in delay of approval or denial of your application. An applicant is ineligible to reapply for a license for 1 year following final department action denying the issuance of or renewal of a license.

### **Basic Qualifications:**

An individual applicant must be at least 18 years of age.

The applicant and each controlling person must be of good moral character, have business integrity, and be financially responsible. A "controlling person" means an individual who possesses the right to direct the management or policies of a professional employer organization or group through ownership of voting securities, by contract or otherwise.

Ability to maintain a positive working capital.

Nonresidents who want to apply for an unrestricted license must also be licensed by the state of domicile if PEO or group licensing is required in that state.

Resident or nonresident unrestricted license applicants must show a tangible accounting net worth of at least \$50,000. If an applicant is unable to meet the \$50,000 net worth requirement, the applicant shall provide to the department a surety bond, a letter of credit, or marketable securities acceptable to the department in an amount of not less than \$50,000 to cover the deficiency.

Restricted licenses for PEOs or groups residing in another state may be issued if:

- the applicant's state of residence licenses PEO's and the applicant is licensed and in good standing, and that state grants a similar privilege for restricted licensing;
- applicant does not maintain an office, sales force, or a sales representative in Montana and does not solicit clients who are residents of or domiciled in Montana; and
- applicant does not have more than 100 leased employees working in Montana.

**WORKER'S COMPENSATION REQUIREMENT:** All operations of a client, whether or not all or a portion of the client's operations are subject to a professional employer arrangement or employee leasing arrangement, must be insured by the same insurer. The workers' compensation insurer is required to report to the workers' compensation advisory or rating organization, all data by client including payroll by classification and liabilities for each client during the term of the policy. The insurer is required to audit policies issued to a PEO within 90 days of the policy effective date and may conduct quarterly audits thereafter.

**Please submit each of the following documents and use the checklist for reference:**

\_\_\_\_\_ Financial Statements-Pursuant to 39-8-202 (6) Montana Code Annotated (MCA) Except for an applicant who is granted a restricted license an applicant shall provide financial statements that have been independently **audited** by a certified public accountant; **or** provide independently **compiled** financial statements **and a \$100,000 security deposit**. The applicant shall maintain a positive working capital, as evidenced by financial statements (reference 39-8-202 (7) MCA)

\_\_\_\_\_ Attestation of Financial Statement (reference 39-8-202 (6)(c)(ii) MCA)

\_\_\_\_\_ File required documents with Montana Secretary of State (reference 39-8-202 (4) (b)-(d) MCA) contact Business Services Bureau (406) 444-3665 or  
[http://sos.mt.gov/BSB/Business\\_Forms.asp](http://sos.mt.gov/BSB/Business_Forms.asp)

\_\_\_\_\_ MT Identification Number (Withholding Tax) (reference 39-8-207 (4)(a) MCA) contact: Montana Department of Revenue (406) 444-6900 or  
<http://www.discoveringmontana.com/revenue/formsandresources/forms/LFUTGenReg.pdf>

\_\_\_\_\_ State Unemployment Tax Account (SUTA) (reference 39-8-207 (4)(b) MCA) contact: Montana Department of Labor and Industry/Unemployment Insurance Division 1-800-550-1513 or  
<http://uid.dli.state.mt.us/tax/uitaxforms.asp>

\_\_\_\_\_ Quarterly submission from independent CPA (reference 39-8-207 (2)(b) MCA)

\_\_\_\_\_ Complete copy of Workers' Compensation policy acknowledging Montana coverage for the client companies. (reference 39-8-207 (4)(c) MCA)

\_\_\_\_\_ PEO Ownership Information form (reference 39-8-202 (4) MCA)

\_\_\_\_\_ PEO Group Guaranty form (reference 39-8-202 (4)(e) MCA)

\_\_\_\_\_ List of Branch Offices (reference 39-8-202 (5)(a) MCA)

\_\_\_\_\_ Business Operational History (reference 39-8-202 (5)(b) MCA)

\_\_\_\_\_ Applicant Authorization for Release of Information form (reference 39-8-202 (5)(c) MCA)

\_\_\_\_\_ Declaration of Accuracy form (reference 39-8-202 (5)(c) MCA)

\_\_\_\_\_ Client Contract Service Agreement (reference 39-8-207 (1) MCA)

\_\_\_\_\_ Employee Notice (reference 39-8-207 (2) MCA)

\_\_\_\_\_ Quarterly payroll-related tax certification for each quarter (reference 39-8-207 (2)(b)

\_\_\_\_\_ List of Montana Client Companies – (reference 39-8-207 (2)(e) currently under contract with the applicant, including the name of the business, their Federal Employer ID number, business address, primary business operation and the beginning date of the contract.

\_\_\_\_\_ Character Reference Affidavit form (must be completed for each person)  
(reference 39-8-102 (3) & 39-8-202 (5)(C) MCA for each of the 4 Controlling Person forms)

\_\_\_\_\_ Applicant/Controlling Person Questionnaire form (must complete for each person)

\_\_\_\_\_ Controlling Person Authorization for Release of Information form (must complete for each person)

\_\_\_\_\_ Applicant/Controlling Person(s) Information form (must complete for each person)

\_\_\_\_\_ Benefit Program Information (reference 39-8-207 (6) MCA)

## PROFESSIONAL EMPLOYER ARRANGEMENT CLIENT INITIATION OR TERMINATION FORM

39-8-207 (2)(e) Montana Code Annotated, states the professional employer organization or group shall: notify the department in writing within 20 days after a client either commences or terminates a professional employer arrangement or an employee leasing arrangement with that professional employer organization or group.

Please furnish a copy of this completed form:

Email: [brwall@mt.gov](mailto:brwall@mt.gov)

Fax: 406-444-3465

State of Montana

Department of Labor & Industry

Employment Relations Division

Attn: Brett Wall

PO Box 8011, Helena MT 59604-8011

1805 Prospect Avenue, Helena MT 59601

Phone: 406-444-0776

DLI/ERD use only

Excel: \_\_\_\_\_

Policy: \_\_\_\_\_

NCCI: \_\_\_\_\_

WCAP: \_\_\_\_\_

UEF Letter: \_\_\_\_\_

Notes: \_\_\_\_\_

### Employee Leasing Company Information:

Name of Company: \_\_\_\_\_

Address of Company: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone # \_\_\_\_\_

Federal Tax ID #: \_\_\_\_\_

=====

### Client Company Information:

Name of Client Company: \_\_\_\_\_

Address of Client Company: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone # \_\_\_\_\_

Federal Tax ID #: \_\_\_\_\_

Month, Day and Year leasing arrangement **initiated**: \_\_\_\_\_

Month, Day and Year leasing arrangement **terminated**: \_\_\_\_\_

Reason for **termination**: \_\_\_\_\_

WC class codes used for this client: \_\_\_\_\_

WC policy number: \_\_\_\_\_ Policy effective date: \_\_\_\_\_

=====

Completed by: \_\_\_\_\_

Date form completed: \_\_\_\_\_

**Note: If applicable, please provide the business location and/or employee status within Montana.**

## ATTESTATION OF FINANCIAL STATEMENT

We, the undersigned, in conformance with section 39-8-202, MCA, do hereby attest to the accuracy and completeness of the financial statements submitted herein and attached hereto by \_\_\_\_\_ (applicant) as part of the application process for licensure as a Professional Employer Organization.

attest: \_\_\_\_\_

_____	_____
Date	Signature and printed name of applicant <b>president</b>

attest: \_\_\_\_\_

_____	_____
Date	Signature and printed name of <b>chief financial officer</b>

attest: \_\_\_\_\_

_____	_____
Date	Signature and printed name of a <b>controlling person</b>

## DECLARATION OF ACCURACY

I, \_\_\_\_\_, declare that to the best of my knowledge the applicant is qualified in all respects for the license for which applied in this application; that all of the questions in this application have been answered truthfully; that all supporting documents, submitted with this application are true, correct, complete and valid; and that there have been no material omissions of fact which would have bearing upon the State of Montana's decision to grant the requested license.

I understand and agree that furnishing false information or failing to disclose material information regarding the applicant's background and qualifications is grounds for refusing to issue a license and/or the revocation of a license already issued. I also understand that making false statements under penalty of perjury may subject me to criminal liability.

I declare that: (check one)

\_\_\_\_\_ I am the named applicant for licensure as a Professional Employer Organization

\_\_\_\_\_ I am the \_\_\_\_\_ (title) of \_\_\_\_\_  
and I have been duly authorized to execute this Declaration on behalf of the applicant.

I declare under penalty of perjury of the laws of the State of Montana that the above statements and the statements made in this Application for Professional Employer Organization License are true and correct. I declare that this declaration was executed on

\_\_\_\_\_, 20\_\_\_\_ at

\_\_\_\_\_ (city), \_\_\_\_\_ (state).

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**Printed name, signature and title of a control person**

**APPLICANT/CONTROLLING PERSON  
INFORMATION SHEET**

A separate form must be completed for each applicant or each controlling person, if applicable.

**1. NAME OF (APPLICANT/CONTROLLING PERSON)**

\_\_\_\_\_  
(Typed or Printed, Full Legal Name – First, Middle, Last)

**2. SOCIAL SECURITY NUMBER** \_\_\_\_\_

**3. MAILING ADDRESS** \_\_\_\_\_  
(Number & Street or PO Box, City, County, State, Zip)

**4. HOME ADDRESS** \_\_\_\_\_  
(Number & Street or PO Box, City, County, State, Zip)

**5. TELEPHONE NUMBER** \_\_\_\_\_  
(Area Code/Number)

**6. DATE OF BIRTH** \_\_\_\_\_

**7. TITLE CONTROLLING PERSON**    ☐ Owner   ☐ Manager   ☐ Other

**8. LIST BELOW** employment history for the last four (4) years, identify management and supervisory positions. (Attach additional sheets if necessary and reference item number.)

EMPLOYER & ADDRESS	DATE FROM/TO	TELEPHONE NUMBER	BRIEF DESCRIPTION OF RESPONSIBILITY
A.			
B.			
C.			
D.			



## APPLICANT/CONTROLLING PERSON QUESTIONNAIRE

The applicant/controlling person should complete this form.

If the answer to any of the following questions is "YES" attach a full explanation detailing the circumstances or condition which cause the "YES" answer. Any bankruptcy within the last 10 years must attach Schedules A & B and the court order discharging the bankruptcy.

	YES	NO
1. Does the applicant, controlling person, officer, director, shareholder, or partner now hold or have they ever held an employee leasing company, or authority to practice as an employee leasing company in the State of Montana or any other state?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the applicant or any officer, controlling person, director, shareholder, member, partner, owner or managing employee:		
a. been convicted of, pled guilty to, or entered a plea of no contest to any criminal violation?	<input type="checkbox"/>	<input type="checkbox"/>
b. ever filed for, or been subjected to an involuntary petition for, or been adjudged bankrupt, or sought protection under the bankruptcy laws?	<input type="checkbox"/>	<input type="checkbox"/>
c. had a judgment entered against them in any court?	<input type="checkbox"/>	<input type="checkbox"/>
d. applied for and been denied a bond?	<input type="checkbox"/>	<input type="checkbox"/>
e. had a bonding company or surety make a financial settlement in their behalf?	<input type="checkbox"/>	<input type="checkbox"/>
f. had a bonding company or surety revoke a bond or surety agreement executed in their behalf?	<input type="checkbox"/>	<input type="checkbox"/>
g. had a license or authority to practice denied, revoked, suspended, placed on probation or been subject to disciplinary action or restriction?	<input type="checkbox"/>	<input type="checkbox"/>

## APPLICANT/CONTROLLING PERSON QUESTIONNAIRE (page two)

YES

NO

3. Are there now any outstanding unpaid past due bills; claims for salaries, wages, benefits or services; judgments, assessments or liens resulting from acts or omissions of this applicant, controlling person, officer, director, shareholder, member, partner, owner, or managing employee, for which these persons may be responsible?

☐☐

I, \_\_\_\_\_, do hereby certify that all of the questions in this applicant/controlling person questionnaire have been answered truthfully; that all supporting documents, submitted with this questionnaire are true, correct, complete and valid; and that there have been no material omissions of fact which would have bearing upon the State's decision to grant the requested license to the Professional Employer Organization applicant.

I understand and agree that furnishing false information or failing to disclose material information regarding the applicant's background and qualifications is grounds for refusing to issue a license and/or the revocation of a license already issued. I also understand that making false statements under penalty of perjury may subject me to criminal liability.

I declare under penalty of perjury of the laws of the State of Montana that the statements made in this Applicant/Controlling Person Questionnaire are true and correct. I declare that this declaration was executed on \_\_\_\_\_, 20\_\_\_\_ at \_\_\_\_\_ (city), \_\_\_\_\_ (state).

\_\_\_\_\_  
Printed name and Signature

## CONTROLLING PERSON AUTHORIZATION FOR RELEASE OF INFORMATION

(A separate form must be completed for each controlling person)

I, \_\_\_\_\_, hereby authorize all persons, institutions, organizations, schools, governmental agencies (including criminal justice agencies and tax authorities), employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in the Applicant/Controlling Person questionnaire, to release to the State of Montana, Department of Labor and Industry, Employment Relations Division ("the Division"), and its employees, agents and attorneys, any files, records or information of any type reasonably required for the Division to properly evaluate my eminence in regard to the application for licensure as a Professional Employer Organization by the State of Montana.

**A copy of this authorization may be used with the same effect as the original.**

\_\_\_\_\_

\_\_\_\_\_

Date	Printed name and Signature
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Date of Birth \_\_\_\_\_

Social Security No. \_\_\_\_\_

**STATE OF MONTANA, DEPARTMENT OF LABOR AND INDUSTRY  
PROFESSIONAL EMPLOYER ORGANIZATION  
CHARACTER REFERENCE AFFIDAVIT**

STATE OF \_\_\_\_\_)

: SS

COUNTY OF \_\_\_\_\_)

\_\_\_\_\_, being first duly sworn says:

1. That I have known \_\_\_\_\_ (printed name of applicant/controlling person) for at least three years and know that he/she is of good moral character and has a reputation for honesty and fair dealing.
2. That I am not related by blood or marriage to the person named in paragraph 1.
3. That I am not a controlling person in the Professional Employer Organization for which this character reference relates.

By: \_\_\_\_\_

(signature of affiant)

**SUBSCRIBED AND SWORN** to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

(Seal)

\_\_\_\_\_  
**Notary Public for the**

**State of** \_\_\_\_\_

**Residing at** \_\_\_\_\_

**My commission expires** \_\_\_\_\_

# PEO OWNERSHIP INFORMATION

Provide information for all owners, partners, corporate officers, shareholders with greater than 5% interest, and limited liability company individuals who have a 5% or greater interest in the company.

NAME	ADDRESS (P.O. BOX NOT ACCEPTABLE)	SOCIAL SECURITY NUMBER	AGE	TITLE	% OF VOTING INTEREST

Use this space to provide “Business Operational History” (reference 39-8-202 (5)(a) MCA)

List by jurisdiction of each name under which the applicant has operated in the preceding 5 years, including any alternative names, names of predecessors, and names of related business entities with common majority ownership.

## APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize all persons, institutions, organizations, schools, governmental agencies (including criminal justice agencies and tax authorities), employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this license application, to release to the State of Montana, Department of Labor and Industry, Employment Relations Division ("the Division"), and its employees, agents and attorneys, any files, records or information of any type reasonably required for the Division to properly evaluate the applicant's qualifications for licensure as a Professional Employer Organization by the State of Montana.

A copy of this authorization may be used with the same effect as the original.

\_\_\_\_\_ **By:** \_\_\_\_\_

\_\_\_\_\_

Date	Printed Name, Signature and Title
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Name of Applicant: \_\_\_\_\_

Applicant's FEIN or Social Security Number: \_\_\_\_\_

# PROFESSIONAL EMPLOYER ORGANIZATION GROUP GUARANTEE FORM

(1 of 2)

Pursuant to the provisions of the Montana Professional Employer Organizations and Groups Licensing Act, the undersigned, hereby: 1) unconditionally guarantee and promise to pay any and all financial obligations of each entity of the group with respect to wages, payroll-related taxes, insurance premiums, and employee benefits; 2) authorize any entity of the group to act on behalf of the group; and 3) guarantee that each PEO within the group is majority-owned by the same person.

Name of Group:

(1) First entity (may also be name of group):

By: \_\_\_\_\_

Printed Name & Signature  
of Controlling Person

State of \_\_\_\_\_

County of \_\_\_\_\_

Before me, personally appeared \_\_\_\_\_ (controlling person), whose identity is known to me by \_\_\_\_\_ (type of identification) and who, under oath, acknowledge their signature appears above. Sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

(Seal)

\_\_\_\_\_  
Notary Public

My Commission Expires:

(2) Second entity: \_\_\_\_\_

By: \_\_\_\_\_

Printed Name & Signature  
of Controlling Person

State of \_\_\_\_\_

County of \_\_\_\_\_

Before me, personally appeared \_\_\_\_\_ (Controlling person), whose identity is known to me by \_\_\_\_\_ (type of identification) and who, under oath, acknowledge their signature appears above. Sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

(Seal)

\_\_\_\_\_  
Notary Public

My Commission Expires:

**PROFESSIONAL EMPLOYER ORGANIZATION GROUP GUARANTEE FORM**  
**(2 of 2)**

**(3)** Third Entity: \_\_\_\_\_

**By:** \_\_\_\_\_

Printed Name & Signature  
of Controlling Person

State of \_\_\_\_\_

County of \_\_\_\_\_

Before me, personally appeared \_\_\_\_\_ (Controlling person), whose identity is known to me by \_\_\_\_\_ (type of identification) and who, under oath, acknowledge their signature appears above. Sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

(Seal)

\_\_\_\_\_  
Notary Public  
My Commission Expires: \_\_\_\_\_

**(4)** Fourth Entity: \_\_\_\_\_

**By:** \_\_\_\_\_

Printed Name & Signature  
of Controlling Person

State of \_\_\_\_\_

County of \_\_\_\_\_

Before me, personally appeared \_\_\_\_\_ (controlling person), whose identity is known to me by \_\_\_\_\_ (type of identification) and who, under oath, acknowledge their signature appears above. Sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

(Seal)

\_\_\_\_\_  
Notary Public  
My Commission Expires: \_\_\_\_\_

**(5)** Fifth Entity: \_\_\_\_\_

**By:** \_\_\_\_\_

Printed Name & Signature  
of Controlling Person

State of \_\_\_\_\_

County of \_\_\_\_\_

Before me, personally appeared \_\_\_\_\_ (controlling person), whose identity is known to me by \_\_\_\_\_ (type of identification) and who, under oath, acknowledge their signature appears above. Sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

(Seal)

\_\_\_\_\_  
Notary Public  
My Commission Expires: \_\_\_\_\_